The purpose of our article was to show that, if phlebography is to be performed, it is better to do it immediately than to admit the patient and perform the investigation during more convenient working hours. The authors' letter appears to have little or no relevance to our original article.

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Cardiac tamponade

SIR,—Dr John Horgan discusses the clinical presentation of cardiac tamponade in terms of respiratory distress and shock and emphasises the importance of early diagnosis (5 September, p 563). A further symptom may help in preventing delay in diagnosis: dysphagia was found in three consecutive cases seen recently at this hospital.

In each case the origin of the tamponade was malignant disease; cytological examination of pericardial fluid and sputum disclosed adenocarcinomatous cells. All three patients (aged 54, 65, 65) were smokers. While each patient complained predominantly of progressive breathlessness, which became rapidly worse around the time of admission, their dysphagia was scarcely less distressing. After pericardiocentesis (the volume of effusion drained ranged from 1·5 to 2·5 litres) not only was breathlessness improved but dysphagia was relieved. This suggests a direct pressure effect of the enlarged pericardial sac on the oesophagus, by analogy with mitral stenosis, where left atrial enlargement may also cause dysphagia.[1]

In a review of pericardial constriction Hirschmann gave dysphagia as a symptom,[2] and Thurber *et al*[3] describe 10 of 55 patients with malignant pericardial disease complaining of dysphagia, but it is not mentioned in the *Oxford Textbook of Medicine*[4] or Hurst's *The Heart*.[5] In any patient with respiratory distress and dysphagia the possibility of cardiac tamponade should be considered.

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1 Dines DE, Anderson MW. Giant left atrium as a cause of dysphagia. *Ann Intern Med* 1966;65:759-61.
2 Hirschmann JV. Pericardial constriction. *Am Heart J* 1978;96: 110-22.
3 Thurber DL, Edwards JE, Archer RWP. Secondary malignant tumours of the pericardium. *Circulation* 1962;26:228.
4 Gibson DG. Pericardial disease. In: Weatherall DJ, Ledingham JGG, Warrell DA, eds. *Oxford textbook of medicine*. 2nd ed. Oxford: Oxford University Press, 1987.
5 Logue RB. Etiology, recognition and management of pericardial disease. In: Hurst JW, ed. *The heart*. 5th ed. New York: McGraw Hill, 1982.

Dysphagia in acute stroke

SIR,—Dr Caroline Gordon and colleagues dealt with dysphagia as a complication of acute stroke (15 August, p 411). Although we would intuitively agree with the points of this paper, we do not think that the main conclusions can be accepted on the evidence given.

There are major methodological problems. Admission criteria are not clearly stated. Patients were entered in the study up to two weeks after the occurrence of an acute stroke. In 44% of cases dysphagia had resolved within two weeks. Some of the "patients without dysphagia" therefore probably did have dysphagia which had resolved by the time of entry in the trial. The assessment of dehydration appears to have been based on fluid balance charts and measurements of packed cell volume and urea concentrations, but they admit that the data collected for both groups of patients are incomplete. Criteria for the definition of chest infection are not given. No statistically significant difference in the incidence of chest infection was found between those with and those without dysphagia. No statistical support is given for the apparent differences in packed cell volume and urea between the two groups.

This study gives clear evidence that dysphagia may complicate unilateral cerebral hemisphere stroke, that it is associated with more severe or multiple strokes, and that it is associated with an increased risk of death (although the assumption that unconscious patients had dysphagia may have confounded the results). The concluding paragraph states that "if dysphagia is identified early after a stroke happens dehydration and chest infections may be prevented with nasogastric tubes or intravenous fluids until swallowing recovers." On the same data it might be rephrased "no significant difference was found in the incidence of chest infection or dehydration between those with and those without dysphagia in the first two weeks of stroke. There are insufficient data to support a change in current medical practice. Further research is needed."

We also have recognised that many of the patients with stroke in our unit have swallowing problems in the early stages. We find it useful to involve a speech therapist in the management and assessment of such patients as soon as they are fully conscious. Swallowing therapy can help to re-establish and coordinate the swallow, even before oral feeding is possible or safe. In some cases a palatal training appliance improves swallowing coordination and drooling. This consists of a wire loop attached to a dental plate. It is well tolerated and easily fitted.[1]

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1 Selley WG. Swallowing difficulties in stroke patients: a new treatment. *Age Ageing* 1985;14:361-5.

AUTHOR'S REPLY,—The admission criteria are stated clearly and covered 91 consecutive patients admitted to a district general hospital with a clinical diagnosis of acute stroke. We think it likely that these patients were typical of patients with stroke admitted to any district general hospital. Sixty one per cent of patients were seen within 48 hours and 90% within 96 hours of the onset of the stroke. Allowing for delays incurred at home, on ambulance journeys, and at weekends, it seems unlikely that the figures could be improved without more staff. We accept that some patients with dysphagia may have been missed. This could have occurred, for example, in patients who died before reaching hospital or those in whom dysphagia was a transient event which cleared rapidly before, or shortly after, admission to hospital. We also accept that more work needs to be done on the problem of dehydration and its consequences.

Criteria for the definition of chest infections are given in the methods section. We agree that the numbers are small and that the difference between the two groups does not reach statistical significance.

We agree that speech therapists can frequently help patients with dysphagia. We also have experiences of using palatal appliances in a different context.[1] We do not think, however, that a palatal training device would be appropriate for a condition that usually resolves within 14 days.

Finally, we cannot agree with the penultimate paragraph of the letter. Dysphagia is a highly dangerous complication of an acute stroke. Swallowing should be tested in all cases, and if the patients cannot swallow some alternative method of giving fluids should be used. This recommendation does not appear in any of the standard textbooks. Certainly more research is needed.

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1 Enderby PM, Langton-Hewer R. Communication and swallowing. In: Cochrane GM, ed. *Management of motor neurone disease*. London: Churchill Livingstone, 1987:34-5.

SIR,—Dr Caroline Gordon and colleagues have confirmed (15 August, p 411) that dysphagia is a common but generally transient problem after stroke affecting a single cerebral hemisphere and that difficulty in swallowing is associated with an increased early mortality. This relation is confounded, however, by the association between dysphagia and overall severity of stroke, which they also showed.

The β blocker stroke (BEST) study carried out in Nottingham is now complete,[1,2] and data are available from 357 conscious stroke victims seen within 48 hours of the onset of strokes that, by clinical criteria, affected only one cerebral hemisphere. From the table it can be seen that the 29% of patients with impairment of swallowing on day 1 were more likely to be drowsy (and to have other adverse signs) but that they had a substantially increased early mortality, regardless of the initial state of alertness. On the other hand, the pattern of clinically determined causes of death was similar in those with and without swallowing problems, apart from an excess of primary brain deaths, which might be expected in a group with more severe strokes. Moreover, the mean changes in packed cell volume and blood urea concentrations over the first week in surviving patients with dysphagia who were not given intravenous or nasogastric fluid did not differ significantly from those in patients who did not have dysphagia.

Thus any tendency to dehydration or chest infection in conscious stroke victims with transient swallowing difficulty may not be severe enough to add substantially to the early mortality, but more research is needed to determine whether failure to

Outcome in 357 stroke victims with or without impairment of swallowing

Swallowing on day 1	No of patients (% mortality in first month)			Total No of deaths in 6 months	% Of deaths attributed to each cause					
	All	Alert	Drowsy		Primary brain death	Pneumonia	Pulmonary embolism	Cardiac*	Renal failure	Other
Normal	250 (10)	210 (7)	40 (23)	40	10	43	25	15	3	5
Impaired	107 (48)	36 (33)	71 (55)	61	20	44	25	10	2	0
Total	357 (21)	246 (11)	111 (43)	101	16	44	25	12	2	2

*Heart failure, myocardial infarction, arrhythmia.

recognise the problem and consequent lack of treatment might aggravate disability in survivors.

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1 Barer D. Lower cranial nerve motor function in unilateral vascular lesions of the cerebral hemisphere. *Br Med J* 1984;289:1622.
2 Barer D, Cruickshank J, Ebrahim S, Mitchell S. Low dose beta blockade in acute stroke (the "BEST" trial). *Br Med J* (in press).

Struggling with malpractice and medical defence subscriptions

SIR,—Several correspondents on the issue of medical defence subscriptions (12 September, p 666) suggest that health authorities should bear the cost on the grounds that it is common practice for employers in industry to take out insurance for their workers.

Such a move will protect hospital doctors from the burden of rising professional indemnity subscriptions. This practice may, however, cause problems. Currently, the defence organisations offer protection not only against claims for negligence from patients but also against actions initiated by the employing authorities on matters related to contractual obligations or by the General Medical Council's disciplinary committees. If the employing authorities pay the defence subscriptions a conflict of interests may arise in defending the doctor against actions initiated by the employer.

As costs of negligence rise defence societies will probably be under pressure to limit or withdraw their support of individual members in cases relating to contractual commitment of professional conduct, especially where negligence to a patient is not in question. In many such instances failure to defend the member successfully will not result in financial losses to the defence organisations. I believe that if employing authorities take over payment of defence subscriptions it is imperative to have separate indemnity dealing solely with problems in disputes entailing the employing authority or the General Medical Council. Subscription for this important protection should be paid by individual members.

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Reviewing RAWP

SIR,—Mr N B Mays (19 September, p 703) calls for greater empirical evidence on whether patients in "socially deprived" areas stay in hospital longer for the same case mix than those in "non-deprived" areas in order to assess the need for an allowance for deprivation in National Health Service resource allocation formulas.

Simple observations of a correlation do not, however, imply causation. As a consequence, enhancing the provision of resources in areas observed to have atypically long lengths of stay generates perverse incentives, encouraging longer lengths of stay in all areas to substantiate further additions to existing allocations, and hence undermines the fundamental principle of a RAWP type formula. The results of a recent comparison of activity between Sheffield and West Lambeth health authorities suggested that observations of longer lengths of stay in inner London districts are less to do with the relative deprivation of the population and more concerned with managerial practices and the efficiency of performance of the particular districts.[1]

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1 George SL, Pitt FA, Watts M. Impact of cuts in acute beds on services for patients. *Br Med J* 1987;294:969.

Determining the incidence of HIV infection

SIR,—The debate surrounding the determination of the incidence of infection with the human immunodeficiency virus (HIV) in the general population in Britain has so far failed to identify an ethically acceptable programme. The continuing need for some system of monitoring HIV seroprevalence, however, cannot be ignored. Indeed, the World Health Organisation emphasises, in its special programme on the acquired immune deficiency syndrome (AIDS), that national AIDS programmes should include the establishment of AIDS and HIV surveillance.[1]

A random sample for whom HIV seropositivity would be of least personal impact would be those killed in road traffic accidents each year (5000 in England and Wales[2]). While the results of such a monitoring scheme would need to be adjusted to reflect the British population, it is noteworthy that the age distribution of people who die in road traffic accidents is similar to the age distribution of people who are sexually active. Furthermore, details of age, sex, and social class would be readily available without the complications that obtaining such details during a random study of HIV seroprevalence among hospital admissions would entail.

Random and anonymous studies all suffer from the limitation that risk group data are inaccessible, a failing noted by the Social Services Committee.[3] The availability of data on social class and geographical locality for those killed in road traffic accidents, however, encourages the review of demographic influences on the spread of HIV, an approach which may outlast the current reliance on risk group classification and which is in line with the World Health Organisation's global strategy.

The current estimate of HIV infection in Britain (30 000-100 000) would be reflected by 3-10 people infected with HIV among those killed in road traffic accidents each year, given a geographically similar distribution of deaths in such accidents and infection with HIV. In fact, because of the preponderance of deaths in road traffic accidents occurring in the sexually active age range there would be a positive bias towards seropositivity for HIV. Such a bias would be neutralised by normalisation of the data but would tend to improve the statistical reliability by increasing the numbers counted. The statistical confidence for one year for Britain would allow no better resolution than the current guesswork. Over time and if the approach were broadened—for instance, to Europe—the study would become more statistically powerful. In any event, it is in the trends of infection that the really crucial pointers for the future lie.

While ethical dilemmas about informing next of kin of positive results would inevitably arise, with the current demand for transplantable organs much of the HIV testing would have been carried out anyway. Thus the HIV state of the British population might be assessed with minimal intrusion and cost to individuals or to society.

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1 World Health Organisation. *Special programme on AIDS. Strategies and structure, projected needs*. Geneva: World Health Organisation, 1987: 5, 9, 14.
2 Office of Population Censuses and Surveys. *Mortality statistics, accidents and violence, England and Wales 1985*. London: Office of Population Censuses and Surveys, 1986. (Series OH4 No 11.)
3 Social Services Committee. *Third report of the social services committee session 1986-87. Problems associated with AIDS*. London: HMSO, 1987:13.

Doctors against nuclear war in Turkey

SIR,—As community physicians we are concerned for Turkish colleagues who currently face government oppression resulting from their wish to publicise the BMA reports on the medical effects of nuclear war.[1,2] Last May these doctors and health workers applied for government permission to form a group opposed to nuclear war but their request was refused on the grounds that they might alarm the public and that they should leave the issue to experts—namely, the Atomic Energy Authority and the Civil Defence Department of the Ministry of the Interior.[1]

Government refusal to recognise this medical group means that Turkey is unique in having prevented its doctors and health workers from becoming affiliates of the Nobel prizewinning International Physicians for the Prevention of Nuclear War (IPPNW). With Albania and Yugoslavia, Turkey is one of only three European countries without affiliate membership of IPPNW, to which more that 50 countries now belong.

A second consequence of government refusal to register Doctors Against Nuclear War is that members of this 60 strong group face the penalties of belonging to an illegal organisation. In Turkey punishment for opposing the government or its regulations can be severe. A number of doctors who opposed increased government control over the universities have been dismissed from their posts without warning.[4] Some have also had their passports withdrawn and have been told they may never work again for a state university or for the state health service. Even more disturbing is the fact that doctors in Turkey, including Dr Erdal Atabek, a past president of the Turkish Medical Association, have been imprisoned. Dr Atabek was imprisoned for membership of the Turkish Peace Association, a multiprofessional group, which existed to support détente and multilateral disarmament. In so far as Turkey is a member of NATO, this abuse of human rights makes a mockery of NATO's claim to defend democratic rights, including that of peaceful dissent.

Letters have been received from the community physician secretary of Doctors Against Nuclear War and also from the secretary general of the Turkish Medical Association asking for our support. We therefore urge the BMA to press for the denial of the European Community membership that Turkey requests until her deplorable human rights record improves.

We also ask individual colleagues to send letters of protest to both their United Kingdom and their European MPs, and to invite Turkish physician members of Doctors Against Nuclear War to professional conferences in Britain as a means of pressing for the return of their passports. We would be glad to supply details to anyone prepared to help in this or any other way.

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